PLAINTIFF'S APPENDIX 6

DukeMedicine

KREMBEL,MICHAEL
MRN: D1316242
DOB: 2/28/1944, Sex: M
Enc. Date:10/15/13

Notes (continued)

Providers Only (continued)

I saw Mr. Michael Krembel, an incarcerated inmate from the Federal Prison System today for the evaluation of a presumed recurrent squamous cell carcinoma of the scalp. Additional information regarding Mr. Krembel's initial evaluation can be found in his database consultative note.

To summarize, Mr. Krembel is an 69 year old Caucasian male who underwent the surgical excision of a histologically-confirmed squamous cell carcinoma of the scalp earlier this year. He has had at least two surgical excisions of this tumor, and his wound was reconstructed with a rotation flap. He had postoperative wound infectious complications that resolved with intravenous antibiotics. Previous CT and MRI staging examinations failed to show any lytic bone involvement. Mr. Krembel's tumor was excised in April, 2013. The excision revealed a moderately to well-differentiated keratinizing squamous cell carcinoma with involvement of a deep inked margin. Mr. Krembel's tumor was re-excised in early May, 2013, and by his consultative notes, the operative surgeon evidently excised the prior margin where deep tumor involvement had been appreciated. Histologic examination of that excision specimen failed to reveal any evidence of persistent squamous cell carcinoma, and the wound was reconstructed with a rotation flap. Mr. Krembel developed clinical evidence of a recurrent squamous cell carcinoma at this site shortly after his rotation flap repair. He was seen by a prison bureau physician on July 8, 2013, and that physician recommended a referral for consideration of the Mohs surgical excision of this presumedly recurrent squamous cell carcinoma, and I saw Mr. Krembel today for this evaluation.

On examination, Mr. Krembel had a well-healed rotation flap in the right crown and vertex area. There were obvious areas of cicatricial alopecia. Additionally, there was a dog-ear protuberance at the pivot point of the flap on the right posterior scalp. At the leading edge of the flap near the central portion of the scalp, Mr. Krembel had an approximately 2-3 cm keratotic nodule with central necrosis. This appeared to represent a clinically recurrent squamous cell carcinoma. On examination, which was limited by the patient's tenderness, the tumor appeared to extend at least to the depth of the underlying periosteum. There were no palpable suggestions of regional lymphadenopathy.

Mr. Krembel was referred to me for a discussion of therapeutic alternatives. He did have a radiation oncology consult in June, 2013. At that time, he had healing wounds on his scalp, but the radiation oncologist noted no obvious suggestions of clinically persistent neoplasia.

I discussed the presumed diagnosis of recurrent squamous cell carcinoma with Mr. Krembel at length. I informed him that no medical or surgical therapy could "guarantee" a permanent escape from eventual regional or distant metastatic disease. I agreed with the prison staff physician that the Mohs surgical excision of this neoplasm would likely have the highest possibility of local tumor control. The Mohs technique was described to Mr. Krembel at length. I have prepared him for the fact that the Mohs surgical excision of this squamous cell carcinoma, which will be confirmed with a biopsy procedure immediately prior to surgical excision, would likely involve an excision of the full-thickness of the scalp down to and including the periosteum. By palpation examination today, Mr. Krembel's squamous cell carcinoma appeared to be rather deep, and I have also mentioned to him that there were certainly possibilities that the underlying calvarium could be involved. Mr. Krembel has had prior radiographic examinations, as noted above, that have failed to reveal any evidence of calvarial involvement. I informed Mr. Krembel that I generally would not favor a repeated imaging study given the possibility of false negative results in this clinical setting and given his extensive scarring in this area. Rather, I would favor a Mohs surgical excision of this neoplasm with detailed analysis of the peripheral and deep surgical margins. Because there would be a rather large area of exposed bone following the surgical excision of this tumor, I informed Mr. Krembel that I would generally favor coordination of the Mohs surgical